

## Durham Research Online

---

### Deposited in DRO:

26 April 2018

### Version of attached file:

Accepted Version

### Peer-review status of attached file:

Peer-reviewed

### Citation for published item:

Campbell, F. and Hackett, S. and Booth, A. and Sutton, A. (2018) 'Young people who display harmful sexual behaviors and their families. A qualitative systematic review of their experiences of professional interventions.', Trauma, violence, and abuse. .

### Further information on publisher's website:

<http://journals.sagepub.com/home/TVA>

### Publisher's copyright statement:

Campbell, F., Hackett, S., Booth, A. Sutton, A. (Accepted). Young people who display harmful sexual behaviors and their families. A qualitative systematic review of their experiences of professional interventions. Trauma, Violence, and Abuse. Copyright © 2018 The Author(s). Reprinted by permission of SAGE Publications

### Additional information:

---

### Use policy

The full-text may be used and/or reproduced, and given to third parties in any format or medium, without prior permission or charge, for personal research or study, educational, or not-for-profit purposes provided that:

- a full bibliographic reference is made to the original source
- a [link](#) is made to the metadata record in DRO
- the full-text is not changed in any way

The full-text must not be sold in any format or medium without the formal permission of the copyright holders.

Please consult the [full DRO policy](#) for further details.

## Trauma, Violence, & Abuse

### **Young people who display harmful sexual behaviors and their families. A qualitative systematic review of their experiences of professional interventions**

Journal:	<i>Trauma, Violence, &amp; Abuse</i>
Manuscript ID	TVA-17-099.R2
Manuscript Type:	Review Manuscripts
Keywords:	Treatment/Intervention < Child Abuse, Offenders < Sexual Assault, Youth Violence

SCHOLARONE™  
Manuscripts

Review

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

**Young people who display harmful sexual behaviors and their families. A qualitative systematic review of their experiences of professional interventions**

**Abstract**

It is estimated that 30-50% of all childhood sexual abuse involves other young people as perpetrators. The treatment of harmful sexual behaviour (HSB) in young people has evolved from interventions developed for use with adult perpetrators of sexual offenses. Increasingly these approaches were not seen as appropriate for use with young people. The purpose of this qualitative systematic review was to establish what intervention components are viewed as acceptable or useful by young people and their families in order to inform the development of interventions for young people with HSB. We conducted searches across 14 electronic databases, as well as contacting experts to identify relevant studies. Thirteen qualitative studies were included in the analysis, reporting findings from intervention studies from the UK, USA, New Zealand, Australia and Ireland. Thematic analysis was used to combine findings from the studies of young people and parent/carers views. Five key themes were identified as critical components of successful interventions for young people with HSB. These included the key role of the relationship between the young person and practitioner, the significance of the role of parents and carers, the importance of considering the wider context in which the abuse has occurred, the role of disclosure in interventions and the need to equip young people with skills as well as knowledge. The evidence was limited by the small number of studies which were mainly from the perspectives of adolescent males.

## Introduction

Since the early 1990s, there has been increasing recognition that children and youth may display sexual behaviors that lie outside normative developmental parameters and can be experienced as harmful or abusive by others (Hackett, 2014). Changing terminology to describe this group of children and their behaviors reflects a shift in understanding and approach away from viewing them simply as ‘mini’ adult sex offenders (Hackett et al 2005) to an approach which embodies a positive and child-centred philosophy (Myers, 2002). In this paper, we use ‘harmful sexual behavior’ as a descriptive term that avoids labelling children as sexual offenders, recognising the considerable variation among children and youth in terms of the nature and range of the harmful sexual behaviors expressed as well as their motivating factors.

Despite increasing interest in youth with harmful sexual behaviors, there is relatively little population-based epidemiological data about such youth or their offenses (Finkelhor, Ormrod and Chaffin, 2009). The largely hidden nature of child sexual abuse makes recognition difficult. The stigma and shame associated with victimisation may lead to under-reporting and the broader social context is one of hostility towards individuals responsible for acts of sexual abuse. All these factors make it difficult to measure accurately the true scale of the problem. Nonetheless, official statistics and existing research suggest that at least a quarter of all sex offenders in the USA are juveniles (Finkelhor, Ormrod and Chaffin, 2009) and that between a fifth and a third of all child sexual abuse in the UK involves other children and adolescents as perpetrators (Hackett, 2014).

An inspection of the effectiveness of multi-agency work with youth with harmful sexual behavior in the UK found that practice responses were generally poor: opportunities for early intervention at the onset of harmful sexual behaviors were often missed; there were few

1  
2  
3  
4  
5  
6 examples where holistic, multi-agency assessments had been undertaken and shared or of  
7  
8 subsequent multi-agency interventions; and case management was often compromised by  
9  
10 poor communication and information sharing (Criminal Justice Joint Inspection, 2013).  
11  
12 Examples of good practice were identified, but the needs of youth were generally poorly met  
13  
14 by the services working directly with them (Criminal Justice Joint Inspection, 2013).  
15  
16 In this review we consider the perspectives of children and youth, and their families,  
17  
18 undergoing interventions for harmful sexual behavior. The work was undertaken as part of an  
19  
20 evidence synthesis of quantitative and qualitative evidence to support the development of  
21  
22 National Institute for Health and Care Excellence (NICE) guidance ‘Harmful sexual  
23  
24 behaviour among children and young people’ (NICE, 2016). The results of the evidence  
25  
26 synthesis of quantitative studies are the focus of a forthcoming article.

27  
28 **Methods**  
29  
30

31 We used a qualitative evidence synthesis methodology for this study, drawing upon  
32  
33 established principles of systematic review. Systematic reviews are undertaken using explicit  
34  
35 and transparent methods to identify, appraise and synthesise research (Gough et al 2012).  
36  
37 Qualitative evidence synthesis is a process of combining evidence from individual qualitative  
38  
39 studies which have undertaken an in-depth enquiry to understand meaning, not to simply  
40  
41 gather a description of how people feel about an issue or a treatment but to reach an  
42  
43 understanding of ‘why’ they feel and behave the way they do (Popay, 2005). Qualitative  
44  
45 research is broadly characterised as studies that use qualitative methods both for data  
46  
47 collection and data analysis (Noyes & Lewin, 2011).

48 **Identification of evidence.**  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

An initial scoping search was conducted across multi-disciplinary bibliographic databases to inform the strategy for the final search. Subsequently, a two-strand approach was applied to the final searches, whereby a search using terms for specific interventions was conducted, followed by a sensitive search using generic intervention terms. We developed the final search terms from the scoping search and in discussion with the NICE team. Thesaurus and free-text terms were utilised, relating to the population (children and youth who demonstrate harmful sexual behavior) and intervention terms. All searches were limited to English Language, Humans, and the publication time span of 1990-Current. All searches were conducted in March 2015 and updated in February 2017. See Appendix 1 for an illustrative strategy from the MEDLINE database. We also undertook citation searching for each identified study following inclusion.

We searched the following electronic databases: MEDLINE, MEDLINE In-Process & Other Non-Indexed Citations, Embase, Cochrane Database of Systematic Reviews, Database of Abstracts of Reviews of Effects, Health Technology Assessment Database, Science Citation Index and Social Sciences Citation Index, Social Care Online, PsycINFO, Social Policy and Practice, EPPICentre – Bibliomap, Dopher, TRoPHI, and The Campbell Library.

We screened all references from the specific search through review of titles and abstracts. We screened references from the sensitive search using the ‘progressive fractions’ technique (Booth et al 2015). This method, developed for undertaking systematic reviews within a time-constrained period, involves conducting a sensitive search strategy in order to populate a project reference management database. The resultant data set is progressively ‘mined’ for titles and abstracts which contain any markers of qualitative research (i.e. “qualitative”, “focus group(s)” or “interview(s)”) until reaching a point of diminished returns (when each progressively less relevant term yields very few, if any, additional studies for inclusion). In

**Comment [AJS1]:** I don't think we need the date ranges unless we are going to include them for each database?

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

this way the time taken in identifying relevant studies is managed so as to be proportionate to the total time available for the completed review.

**Inclusion of Relevant Evidence**

We included studies that examined experiences of children and youth (aged < 21 years) who had received interventions for harmful sexual behavior or that elicited the experiences of parents or carers. We included studies that used qualitative methods of data collection and analysis, or mixed methods studies where qualitative findings were reported. By including studies that elicit views of youth and/or their care givers we could examine their experiences to inform an understanding of service provision from the perspectives of those receiving them. Both published and unpublished studies were considered.

**Methods of synthesis**

For the purpose of the original NICE guidance, and given the practical time constraints, our preliminary synthesis involved coding of verbatim extracts and author observations against broad themes generated from the data. Subsequently, we identified the potential to revisit the data using a more formal and reflexive synthesis process conducted within a more considered timeframe. For this re-analysis we used thematic synthesis as a technique for identifying, analysing and reporting patterns or themes within the data (Braun & Clarke, 2006; Thomas & Harden, 2008). Thematic synthesis combines and adapts approaches from both meta-ethnography and grounded theory (Barnett-Page and Thomas (2009) and was developed out of a need to conduct reviews that addressed questions relating to intervention need, appropriateness and acceptability, to complement those relating to effectiveness. The first stage of our thematic synthesis involved identification of themes across the included studies. This activity is primarily concerned with translating the findings of studies into a common language so that it is possible to compare and contrast findings across studies. The aim at this

stage is to be descriptive, remaining close to the text contained in the primary studies. In this review, we included both the reported primary findings, i.e. what the participants have said or are reported to have said and the authors own interpretations as findings. Each entire paper was treated as 'data' and subject to line-by-line coding of text using NVivo (version 11) software. As a result of careful reading and coding, underpinning themes and concepts were identified. Once applied to the first study, the themes were then applied to the next study using a process of constant comparison. If the text revealed new concepts that did not fit with the existing themes then a new theme was created. In the second stage of the analysis, analytical themes were generated, taking the synthesis beyond the content of the primary studies, to provide new conceptualisations and explanations to address the review questions. Common and divergent concepts were explored. In order to further explore the interrelationships between themes and to develop higher-order analytical themes, in order to understand the elements of interventions that lead to positive behavior change.

### Quality assessment

We assessed the quality of individual studies using the CASP checklist for qualitative research (Critical Appraisal Skills Programme (2017), which explores dimensions of study design reported in the paper. The CASP checklist is consistently the appraisal tool most commonly used within qualitative systematic reviews and allows assessment of the resulting transferability and trustworthiness of the study findings (Hannes et al 2012). In accordance with the NICE guidance for reviewing scientific evidence we rated each study as '++', '+' or '-' indicating high, medium or low quality evidence determined by the extent to which the checklist criteria had been fulfilled (NICE 2012). No studies were excluded on the basis of the quality appraisal but the process was used to aid exploration and interpretation of the study findings (Noyes et al 2017). Clearly, a distinction may be made between quality of studies and the quality of the underpinning interventions described in the studies. For



1  
2  
3  
4  
5  
6 example, it is possible that a well-designed and credible qualitative study could explore an  
7  
8 intervention that is not shown to be effective with empirical studies. However, as our focus in  
9  
10 the paper is not on the validity of the various interventions themselves, but on the experiences  
11  
12 of service users of a range of interventions, we believe that including a diversity of types of  
13  
14 intervention strengthens, rather than weakens our approach.  
15

16 **Results**

17  
18  
19 The search yielded 2405 citations. Of these, 2209 were ineligible after review of the title and  
20  
21 abstract. Of the remaining 196 studies, 183 were excluded following application of the pre-  
22  
23 specified criteria for inclusion. Excluded items comprised items that, on close inspection of  
24  
25 the full text, were not eligible, abstracts that contained insufficient detail, or dissertations or  
26  
27 other items that were unavailable within the constraints of the review. Thirteen studies were  
28  
29 included in the review and are summarised in Table One. Included papers were published  
30  
31 between 2002 and 2014 and were conducted in the United States, United Kingdom, Australia,  
32  
33 New Zealand, Ireland and South Africa. All of the studies used interviews to gather data.  
34  
35 Two studies used focus groups and one direct observation in addition to interviews.  
36

37  
38 The results of quality assessment are presented in Appendix B. Only three papers were rated  
39  
40 as being high quality (++) (Draper et al., 2013; Geary et al., 2011; Halse et al., 2012) six  
41  
42 medium (+) (Belton et al., 2014; Duane et al., 2002; Jones, 2015; Pierce, 2011; Somervell &  
43  
44 Lambie, 2009 Miller, 2011;) and four low (-) (Lambie et al., 2000; Lawson, 2003; Martin,  
45  
46 1994; Slattery et al., 2012). Areas where papers received low ratings include: the unclear role  
47  
48 of the researcher; the thin description of context; the uncertain reliability of analysis; and the  
49  
50 lack of 'richness' of the data reported. As observed in previous qualitative systematic reviews,  
51  
52 we found that these low quality studies contributed less to the findings. (Carroll et al 2012)  
53  
54  
55  
56  
57  
58  
59  
60

## Study Findings

Seven studies reported the views and experiences of adolescents who were participating, or had participated in a treatment programme specifically designed to treat harmful sexual behavior (Belton et al., 2014; Geary et al., 2011; Halse et al., 2012; Lawson, 2003; Martin, 1994; Miller, 2011; Slattery et al., 2012). Three studies focused on the experiences of adolescents undergoing sexual offender treatment which incorporated a physical activity (Draper et al., 2013; Lambie et al., 2000; Somervell & Lambie, 2009). Three studies explored the experiences of parents of adolescents who had sexually offended and were participating in treatment programmes (Duane et al., 2002; Jones, 2015; Pierce, 2011).

Five major themes were identified from the perspectives of youths and their carers as being central to successful interventions. These were: the key role of the practitioner/therapist; the key role of parents/caregivers; seeing the bigger picture; communication and disclosure; and developing self and learning skills. Table Two lists the studies that reported or discussed each theme.

### *The key role of the practitioner*

The relationship that the youth develops with the practitioner was described in five studies as critical to intervention engagement, the acquisition of skills, and to positive outcomes (Belton et al., 2014; Draper et al., 2013; Geary et al., 2011; Halse et al., 2012; Lawson, 2003). In these studies, the practitioner role most frequently mentioned by youth was that of a confidante; someone with whom the young person felt able to be open and to talk. In such circumstances, youths were able to share emotions with the practitioner that were otherwise difficult to express. The practitioner also performed an important role as an advisor or

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

24 educator. Youths sought them out for information and help with acquiring the skills they  
25 needed to address their harmful sexual behaviors.

26 "i got more than enough time, if i ever wanted to say anything. i mean i used to  
27 always apologise to him for changing the subject but he said "it's fine, it's fine". if i  
28 just need a question answering or some advice on anything you can always ask.well, i  
29 could anyway." Belton et al (2014) 28

31 In one study, the practitioner also provided a quasi-paternal role model (Draper et al., 2013),  
32 modelling appropriate and non-violent behavior to adolescent males who often did not have a  
33 male parental figure.

34 Several practitioner attributes were described as enabling the development of an effective  
35 therapeutic relationship between the youth and the practitioner. Most frequently cited was a  
36 non-judgemental approach; creating an environment in which young people did not feel  
37 labelled by their past behaviors (Draper et al 2013). Such an approach was critical to the  
38 development of a relationship in which the youth felt safe and within which trust could  
39 develop. Adolescents also valued practitioners who listened attentively, enabling openness.  
40 The development of trust was helped when the youth had a sense of being understood by the  
41 practitioner. Trust was facilitated by the practitioner sharing, or showing an interest, in the  
42 interests of the youth (Belton et al., 2014; Geary et al., 2011). Knowledge of the adolescent's  
43 interests proved helpful when designing tailored and relevant strategies (Geary et al.,  
44 2011).Other practitioner attributes that youth described as finding helpful included; being  
45 understanding, caring, encouraging, challenging, supportive, respectful and maintaining a  
46 sense of humour. Such positive behaviors also helped in setting boundaries for what was and  
47 was not acceptable. Being able to relate to the therapist was facilitated in one study by the  
48 therapist and young sharing a black and minority ethnic background (Geary et al., 2011).

49 Factors that were described by youths as hindering the development of the therapeutic  
50 relationship occurred when the practitioner was also advising and supporting parents, proving

to have a detrimental effect on establishment of trust (Belton et al 2014). Youth also considered it unhelpful when there was a lack of continuity between therapist and the practitioner who had previously undertaken the assessment. The assessment process enabled a relationship of trust to start to build and it was unhelpful for young people if this was then disrupted (Belton et al 2014). Other practitioner behaviors which were unhelpful included poor time management and lack of courtesy, failure to notify of changes to appointments, not replying to messages and missing sessions. When practitioners expressed anger and used difficult language, this was seen by youth as a barrier to the development of a positive and trusting relationships (Geary et al 2011).

Two studies (Lambie et al., 2000; Somervell & Lambie, 2009) evaluated interventions which included outdoor activities as part of the therapeutic intervention (so-called 'Wilderness therapy') and another including boxing in the 'Fight with Insight' programme (Draper et al., 2013). The activities required the learning of specific skills together with values such as respect and discipline that could be transferred to other areas of the young persons' lives and could help to build relationships and trust. Engaging in such activities could lead to greater self-confidence and self-discipline.

In one study (Slattery et al., 2012), the role of the practitioner did not appear as important for youth. This may reflect the nature of the intervention involved, which did not rely on one-to-one work. This study evaluated a community-based treatment programme, and targeted adolescent males serving sentences for sex offences. The intervention was psycho-educational and covered target areas (anger management, drugs and alcohol, emotions and coping, empathy, offence-specific, relationships and sex and sexuality) in 6 weekly group sessions (Slattery et al 2012). This finding was reported in a study (Slattery et al 2012) judged to be of poorer methodological quality. A lack of rigour in the methodology may impede the richness of the findings and the rigour of these results. In studies using

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

76 qualitative data as part of the evaluation, and where key workers or practitioners worked on a  
77 one-to-one basis, the practitioner role did appear to be a particularly valued element of the  
78 overall intervention for youth, especially when the practitioner possessed the positive  
79 attributes described above.

80 ***The key role of parents/caregivers***

81 A strong theme in the included studies was the key role that parents or caregivers played in  
82 successful interventions for youth with harmful sexual behaviors. Many youths valued the  
83 involvement of parents and caregivers feeling that without such support they would not have  
84 remained engaged with the work. Parental or caregiver involvement took diverse forms  
85 including supporting youth to attend the programmes, reinforcing consistent messages about  
86 the intervention and helping to reinforce the work after sessions (Belton et al., 2014, Draper  
87 et al., 2013, Lawson, 2003). Additionally, parents and caregivers played an important role in  
88 helping to keep youth safe by monitoring and setting up barriers to reduce the likelihood of  
89 reoffending (Geary et al., 2014, Jones, 2015). Families also provided a source of clemency to  
90 the adolescent who had violated social norms (Lawson, 2003). Parents' participation  
91 demonstrated love, despite the offending, which encouraged engagement with the programme  
92 (Geary et al., 2011). Parents were expected to reinforce strict behavioral guidelines to prevent  
93 relapse, as well as recognising the need for open communication with their child (Jones,  
94 2015).

95 However, the data also reveals challenges experienced by parents because of their child's  
96 harmful sexual behavior that may hinder and limit their capacity to provide support. In one  
97 study (Jones, 2014), the burden upon parents to undertake roles in the supervision and  
98 support of their child who had committed a sexual offence meant that the parents felt that  
99 they themselves were being punished. Parents often felt stigmatised and alone with

1  
2  
3  
4  
5  
6 100 overwhelming feelings of grief, shame, loss and hatred. Parents sometimes also experienced  
7  
8 101 isolation and stigma, sometimes becoming victims of verbal abuse and threats within their  
9  
10 102 communities (Duane et al., 2002). They could feel deskilled as a parent and helpless  
11  
12 103 regarding their child's offence (Duane et al., 2002), feeling that the behavior represented a  
13  
14 104 failure on their part (Pierce, 2011):

15  
16 105 *... it's always there in your mind that you did something wrong, that you must have failed*  
17 106 *him somewhere, to make him go that direction, you know? ... there's a certain amount of*  
18 107 *guilt for me, you know, cos I think ... em maybe if I had of spoken to him or ... you know he*  
19 108 *wouldn't have done this.* (Duane et al., 2002: 55)

20  
21 109 For some parents, their child's harmful sexual behavior was analogous to a trauma:

22  
23 110 *You have to be brave and strong, kind of like if your kid had cancer. You'd have to put on the*  
24 111 *brave face and you may fall apart in your private times, but you have to be strong and brave .*  
25 112 *. . We were traumatized; I still don't know how I got out of bed every day and functioned.*  
26 113 *When we first found out about this, he went to a counselor and he kind of described this as a*  
27 114 *type of death, except without the sympathy. It is a death where you don't have any support.*  
28 115 (Jones et al., 2015: 1312)

29  
30 116 Not all parents or caregivers became actively involved in the intervention programme, in  
31  
32 117 some instances, the young person's offenses led to greater estrangement (Jones, 2015). In one  
33  
34 118 study parents described having lost hope for their child's future and they grieved for what  
35  
36 119 could have been (Pierce, 2011). Relationships became marred by distrust and hatred:

37  
38 120 *One father whose son had committed an intra-familial offence struggled with divided*  
39 121 *loyalties between his son and daughter, saying "But still it's like hatred for one, you know..."*  
40 122 (Duane et al., 2002: 53)

41 123 For parents, accepting that their child had carried out a sexual offence required a process of  
42  
43 124 adjustment, and one which may not run smoothly, leaving parents in a vicious cycle of  
44  
45 125 confusion, searching for answers, disbelief, minimisation of the offense and a return once  
46  
47 126 again to confusion (Duane et al., 2002).

48  
49 127 Some parents experienced denial, finding it difficult to believe that their child had committed  
50  
51 128 a sexual offence (Pierce, 2011) and they transferred blame to the victim of the offense (Jones,

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

2016). Such denial could undermine the work carried out on the programme. Sometimes it was clear that the parent or carer did not feel able to fulfil their expected roles, for example in supporting the young person with homework required between sessions (Belton et al., 2014). Other parents were supportive of their child but were themselves struggling to make the changes needed, for example being able to talk openly to their child about their sexual behavior. Sometimes, parental health or personal problems limited their capacity to support their child. The burden could be overwhelming and lead to feelings of helplessness, frustration, anger and personal defeat (Jones, 2015). A sense of shame could also limit their ability to engage in the treatment programme (Pierce, 2011). Parental groupwork could help to reduce a sense of isolation and stigmatization and sharing experiences with other parents in similar situations could ease their feelings of guilt (Geary et al., 2011). Parents needed someone to talk to without them feeling that they were being judged (Pierce, 2011). Parents' anxieties were greatly eased by friendly, approachable and respectful behaviors of reception and therapeutic staff at the outset of treatment (Geary et al., 2011). Hearing the stories of adolescents who had completed the programme also gave them a sense of hope (Geary et al., 2011). Interventions that incorporated family therapy appear to have positive benefits, aiding communication and helping to restore relationships (Geary et al., 2011).

*Seeing the bigger picture*

Youths felt that interventions that tried to understand their harmful sexual behavior within their wider life context were better able to identify their needs and to support them in changing. Involving the young person's wider network, family, school and other social groups and community activities contributed to successful programmes (Geary et al., 2011).

1  
2  
3  
4  
5  
6 152 Wider involvement supported rehabilitation by enabling adolescents to practice what they  
7  
8 153 had learnt in a safe and contained environment.  
9  
10  
11 154 External contextual factors in the lives of the youths affected their ability to implement  
12  
13 155 material learnt in the programme. Where there was instability, change or other entrenched  
14  
15 156 problems, the young person had limited capacity to apply what they had learnt through the  
16  
17 157 programme (Belton et al., 2014). Impaired learning abilities could also influence how an  
18  
19 158 adolescent engaged with the programme (Belton et al., 2014). To be used effectively, the  
20  
21 159 material needed to take into account both development and contextual issues (Geary et al.,  
22  
23 160 2011). Drug and alcohol misuse could also be factors contributing to a youth's difficulties  
24  
25 161 (Slattery et al., 2012). The youths' own experience of abuse and neglect needed to be taken  
26  
27 162 into account when tailoring the intervention to their needs (Belton et al., 2014). This was a  
28  
29 163 particularly striking explanatory narrative used by young women who were in a correctional  
30  
31 164 centre having committed a sexual offence. The young women were directed to see previous  
32  
33 165 sexual victimization as instrumental in the development of their harmful sexual behavior  
34  
35 166 (Miller, 2011).  
36  
37 167 Seeing the youth within the context of this 'bigger picture' not only related to identifying the  
38  
39 168 challenges and problems they were facing, but also enabled them to change their self-  
40  
41 169 perception away from identification as a sexual offender towards the picture of a young  
42  
43 170 person on a journey towards becoming a 'success story', and the behavior representing not  
44  
45 171 what they 'are' but what they 'did' (Lawson, 2003, Miller, 2011).

46 172 At first I was reluctant [to take responsibility] but then IU was open to it. My  
47 173 favourite saying is – well one that I came up with is – 'What you done is just that:  
48 174 What you've done, not who you are.' Miller et al 2011, 320  
49 175  
50 176

### *Communication and disclosure*



1  
2  
3  
4  
5  
6 177 An important element of successful interventions, not only as part of the intervention but also  
7  
8 178 as an outcome of the intervention, was the youth communicating effectively with the  
9  
10 179 therapist, family members and more widely. Learning to share information appropriately was  
11  
12 180 critical to achieving a positive outcome (Lawson, 2003). Openness in talking was considered  
13  
14 181 evidence of positive engagement in therapeutic work (Miller, 2011; Somervell & Lambie,  
15  
16 182 2009).

17  
18 183 However, adolescents often found this very difficult. Describing and taking responsibility for  
19  
20 184 their offending via disclosure was frequently a difficult and embarrassing task (Somervell &  
21  
22 185 Lambie 2009). In most interventions, youth were expected, as a necessary element of the  
23  
24 186 treatment, to be able to discuss information about their harmful sexual behavior and its  
25  
26 187 impact on victims, themselves and their families. In one study with young women, the  
27  
28 188 intervention was described as socialization into a ‘talking orientation’ (Miller, 2011). Often  
29  
30 189 such conversations were so difficult that youth would avoid being honest with the practitioner  
31  
32 190 (Belton et al., 2014). However, disclosure was viewed as a marker of progress, indicating that  
33  
34 191 the young person was accepting full responsibility for what they had done. Parents regarded  
35  
36 192 disclosure as a very significant step in their child’s progress (Duane et al., 2002). Where this  
37  
38 193 worked well it appeared to offer considerable benefits as exemplified by one young man:

39  
40 194 *“I’ve no thoughts now about anything, I’ve got it all out my head and it’s all cleared. That’s*  
41 195 *got the pressure off me as I’ve been able to talk and explain things and tell them things. If I*  
42 196 *keep it all bottled up it would explode.”* (Belton et al., 2014: 43)

43 197 Interventions that incorporated activities and groupwork appeared to help some youth to  
44  
45 198 share information (Draper et al., 2013). The opportunity for adolescents to challenge and  
46  
47 199 support each other was regarded as a key strength of an intervention programme, as indicated  
48  
49 200 by one young person:

201 *"I get feedback from the group. It's read to me. It helps me get different views from different*  
202 *sides of the square. Everybody sees different things\*everybody's challenging me\*I get a*  
203 *whole picture of myself."* (Geary et al, 2011, pg 190)

204 The studies evaluating 'wilderness therapy' described how being 'on camp' helped  
205 adolescents with disclosure. Being away from their normal environment, sharing the new  
206 terrain and experiences with the group and having time facilitated disclosure (Somervell &  
207 Lambie 2009). The experience of being on camp also contributed to the ability of youth to  
208 engage in disclosure by enabling a more positive view of self and enhanced relationships with  
209 peers.

210 However, group therapy could present difficulties for others because it required them to talk  
211 openly about their sexual behaviors and other problems in front of others. While the accounts  
212 within the studies suggested the importance of openness and sharing as an important  
213 indication of progress, some of the potential dangers were highlighted in one study of young  
214 women in a correctional centre (Miller, 2011). The expectations of disclosure could lead to  
215 youth superficially adopting the narratives of others:

216 *"At times, a participant's narrative sounded as if she was parroting something she had heard*  
217 *from someone else. Other times, a participant directly referenced ways that correctional*  
218 *facility treatment staff had interpreted the young woman's past actions to her.* (Miller 2011:  
219 317).

220 It may be that the expectation of disclosure, and its use as a marker of progress and as an  
221 indicator of success, may not work for all children and youth. Expectations of disclosure may  
222 lead to the development of 'false narratives', ones they feel others want to hear. Tailoring an  
223 intervention needs careful work in understanding ways the child communicates, the best  
224 means of supporting disclosure, and careful non-judgemental listening.

### 225 ***Developing self and learning skills***

226 Another theme in many of the interventions valued by youth and carers was that of building  
227 skills in managing offending behavior by developing their social competency, self-esteem

1  
2  
3  
4  
5  
6 228 and self-efficacy. These were considered critical to the long-term success of interventions,  
7  
8 229 essentially equipping the youth with attributes needed to prevent future reoffending. The  
9  
10 230 interventions included skills in identifying triggers to sexually abusive behavior and  
11  
12 231 strategies to deal with such triggers (Belton et al., 2014; Duane et al., 2002), skills in  
13  
14 232 handling high risk situations (Lawson, 2003) and skills in managing anger and impulsivity  
15  
16 233 (Belton et al., 2014; Draper et al., 2011; Geary et al., 2011). Improved skills in anger  
17  
18 234 management, self-esteem, personal responsibility and in communicating were felt by  
19  
20 235 participants to lead to improved relationships with family members, peers and in turn these  
21  
22 236 served to further improve self-esteem (Halse et al., 2012).  
23  
24 237 In particular, activity based interventions, which required intense involvement, physical  
25  
26 238 challenges, natural consequences, group work and away from familiar environments were  
27  
28 239 viewed positively by participants. Indeed it was the intensity of these experiences and the  
29  
30 240 rather than the practical skills themselves that the young people appeared to value and helped  
31  
32 241 them to engage with the process of therapy (Somervell & Lambie (2017). In other studies,  
33  
34 242 some skills were not always sufficiently well practiced. One example was the development of  
35  
36 243 empathic skills with few able to articulate how their behaviours may have impacted  
37  
38 244 negatively on their victims and caused them emotional pain (Halse et al., 2012). Empathy is a  
39  
40 245 feature that may be developmentally sensitive and empathic skills may not be fully formed  
41  
42 246 until into adulthood, therefore this element of skills development may need careful and  
43  
44 247 realistic planning. More broadly, it is clear that simply having knowledge (e.g. about the  
45  
46 248 harm created by sexually abusive behavior) does not guarantee being able to act appropriately  
47  
48 249 on that knowledge, hence the importance of skills development. Lawson (2003), for example,  
49  
50 250 found that:  
51  
52 251 *Knowing the right thing to do did not guarantee they could do the right thing without help.*  
53  
54 252 (Lawson, 2003: 265)

## 253 Implications

254 The studies included in this qualitative systematic review add to knowledge about successful  
255 interventions for children and youth with harmful sexual behaviours and their families.  
256 Importantly, this paper has outlined five themes of importance to youth and carers who have  
257 received services because of their harmful sexual behavior. These include the critical role of  
258 the relationship with the practitioner, the needs and important role of carers, the need to see  
259 the youth's wider context in tailoring interventions, developing their skills as well as  
260 knowledge, and the role of sharing and disclosure. These core findings resonate with the  
261 philosophical approach described by leaders in the field of harmful sexual behavior in  
262 childhood for over the last two decades which have emphasised the importance of  
263 developmental, familial and contextual approaches (such as the work of Chaffin et al 2002;  
264 Ryan, 2000; Hackett et al., 2006; Letourneau and Borduin, 2008; Creedon, 2013). Whilst  
265 therefore, far from novel, the findings of the current review are however significant as  
266 published user perspectives are rare in the field of sexual aggression, particularly given a  
267 continued dominant emphasis on quantitative research methodologies. In one of the few  
268 international studies addressing user perspectives relating to youth who had sexually abused  
269 others, Hackett et al (2006) argue that the lack of research into user views and experiences  
270 constitutes a glaring omission in the sexual aggression field, reflecting a traditional  
271 standpoint of youth who have committed sexual offences as unreliable and an orientation of  
272 control rather than empowerment. By contrast, they suggest that practitioners have much to  
273 learn from users about their experiences of professionals. The qualitative studies analysed in  
274 the current review, though not exclusively reporting user experiences, each contain the direct  
275 testimony of users. Taken together they highlight a range of core factors of importance that  
276 can inform the development of interventions that benefit from the lived experiences of those  
277 at the receiving end of interventions.

1  
2  
3  
4  
5  
6 278 Some messages for the development of practice responses to harmful sexual behaviour in  
7  
8 279 childhood and youth emerge strongly. First, whilst it is now widely accepted that  
9  
10 280 interventions should be supported by parents and carers (Letourneau and Borduin, 2008),  
11  
12 281 practitioners should be careful to address the needs of parents and caregivers before  
13  
14 282 expecting them to support their child in treatment. The evidence from these studies suggests  
15  
16 283 that parents may need particularly extensive support at the outset of the intervention process  
17  
18 284 in order to come to terms with what their child had done. The outset of treatment is a time  
19  
20 285 where denial and confusion is likely to be particularly challenging, but this challenge may not  
21  
22 286 in itself prove indicative of the capacity of parents, with support, to move from resistance to  
23  
24 287 acceptance of the abuse and of their role in challenging it. Parents therefore need support to  
25  
26 288 assist them in understanding what has happened, in achieving acceptance of the situation and  
27  
28 289 in supporting their child. Such interventions should be tailored to the needs of individual  
29  
30 290 situations, as parents' experiences of self-blame and the process and timescale required for  
31  
32 291 them to address these issues are likely to vary considerably. Interventions with parents and  
33  
34 292 carers should support them in their transition and focus on the strengths they have that can  
35  
36 293 contribute to supporting their child (Jones, 2015). Parents need to be encouraged to openly  
37  
38 294 communicate how they feel and they need help acknowledging and accepting that the offense  
39  
40 295 did occur (Pierce, 2011).  
41  
42 296 Second, the studies in this review support the move towards interventions that focus on the  
43  
44 297 whole person, rather than merely on offence-focused work targeting the harmful sexual  
45  
46 298 behavior. Practitioners need to be able to hear and respond to events in youth's broader lives  
47  
48 299 and in their wider social context so that they can tailor their interventions to support them in  
49  
50 300 developing an identity that is free from sexual deviance (Lawson, 2003). As such, the  
51  
52 301 findings of this review support the move towards models such as Multi Systemic Therapy  
53  
54  
55  
56  
57  
58  
59  
60

(Letourneau et al, 2013), The Good Lives Model (Wylie & Griffin, 2013) and resilience based models (Hackett, 2006) which seek to address the broader social context.

Third, the findings of the review reinforce the move towards relational, or relationship based, practice with children and youth who present with harmful sexual behavior. Young people themselves are clear that they need practitioners with a particular skill-set and with a range of personal attributes and abilities if they are to benefit from programmes of work undertaken with them. It is critical that the practitioner is skilled, able to maintain consistent tailored support from assessment throughout the process from assessment to completing therapeutic work.

Finally, knowledge based programmes are limited without paying attention to the concomitant skills development elements. Opportunities must be provided to reinforce learning – such as activity based work. Activities may have a particularly valuable place in helping youth who have sexually abused others to build relationships with therapists and peers, affording a ‘safe’ place to develop skills and put into practice the skills being learnt. Therapeutic services for children and youth with harmful sexual behaviors and their families need to be nuanced and tailored. Building on the findings of this review, what would such a ‘tailored’ service look like? It would address the sexual behaviors causing concern and harm directly but sensitively, but it would also carefully explore the context in which the behaviors developed. As such, it would address family relationships and attachments and it would consider the role of earlier life experiences, such as of victimisation and trauma as underlying developmental influences. It would, however, go beyond the family to consider school, friendships and wider environmental factors that could act both as risk and protective factors. Critically, it would carefully address the cultural implications of the approach being offered, particularly the power of positive relationships, recognising too that groupwork and one-to-one work may impact differently at different times in the life of a child.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

327 This review was limited to the experiences of participants in the included primary studies  
328 and, through the challenges of study recruitment, will have under-represented the  
329 perspectives of those who withdrew from treatment, or who declined to participate in  
330 treatment. It also did not capture the views of younger children (pre-adolescent) and their  
331 parents, nor the views of young women, or youth with learning difficulties and their parents  
332 and carers. The review was further limited in that the included studies mainly focused on  
333 adolescent male sex offenders, and/or their parents. The range of interventions explored was  
334 quite diverse, requiring a focus on shared mechanisms rather than individual intervention  
335 components. Further research that includes the views of those youth who have not had  
336 successful experiences is needed, as are the views of children and youth who are at present  
337 poorly represented in this data, including those with learning difficulties and their families,  
338 the views of parents of younger children and young women. There is also a need to hear the  
339 experiences of siblings of youth who have sexually abused, so that their needs are understood  
340 and to ensure that interventions protect and enhance their wellbeing.

341 This is a systematic review of qualitative studies, designed to elicit views and attitudes of the  
342 respondents. A limitation when interviewing people is the strong tendency to give socially  
343 desirable answers (Kelle 2006). Additionally, peoples' explanation of their own feelings,  
344 judgements and behaviors are often incorrect and sometimes people have difficulty in  
345 knowing the exact determinants of their attitudes and feelings (Wilson & Stone 1985, Wilson  
346 (2013). Indeed, examples exist where positive attitudes of proponents of a programme for  
347 young offenders, including the views of the young people themselves, do not result in  
348 improved outcomes. The evaluation of 'scared straight' models of crime prevention  
349 strategies whilst, viewed positively by the judicial service, the community, parents and young  
350 people themselves, found that the programmes may actually increase the likelihood of  
351 reoffending and of negative attitudes toward the criminal justice system, when compared with

those not receiving the intervention (Klenowski et al 2010, Homant et al 1982). It is therefore important to review the qualitative evidence alongside studies designed to test effectiveness empirically. For this our parallel publication seeks to examine the outcomes of intervention for young people with HSB.

## Conclusion

Our qualitative evidence synthesis of empirical research studies that have sought the views of youth who have exhibited harmful sexual behaviors and their families has identified features of interventions that appear critical to their success. While there remain gaps in knowledge, this work nonetheless provides guidance for the development and implementation of services that are appropriate for such children. In particular, this review has highlighted the context dependent nature of harmful sexual behaviors and how important it is to understand the mechanisms that lead to positive outcomes so that these can be used to inform intervention design and delivery.



1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

Appendix A – Search terms from MEDLINE (Illustrative example)

Searches

Population Terms

1 (sex\* adj2 (harm\* or risk\* or abus\* or agress\* or unacceptable or offen\* or force\* or impos\* or overly or  
coer\* or inappropriate\* or manipul\* or stigma\* or shame or victim\* or danger\* or threat\* or assault\* or  
pressure\* or violent or violence)).ti,ab.  
2 (problem\* adj2 sex\* adj2 (behavio?r\* or conduct\*)).ti,ab.  
3 \*Sex Offenses/  
4 \*Rape/  
5 (rape or rapist).ti,ab.  
6 \*Unsafe Sex/  
7 (unsafe adj2 sex).ti,ab.  
8 or/1-7  
9 (harm\* or unacceptable or force\* or impos\* or coer\* or inappropriate\* or danger\* or threat\* or assault\* or  
pressure\* or violent or violence).ti,ab.  
10 \*Sexual Behavior/  
11 (coitus or sexual intercourse).ti,ab.  
12 (penetrat\* adj2 sex).ti,ab.  
13 \*Coitus/  
14 (masturbat\* or self stimulat\$).ti,ab.  
15 \*Masturbation/  
16 (sexual interaction or sexual exploration).ti,ab.  
17 or/10-16  
18 9 and 17  
19 inappropriate touching.ti,ab.  
20 (harm\* or unacceptable or innappropraite\*).ti,ab.  
21 ((sexual\* adj3 (swear\* or word\* or phrase\* or slang or jargon)) or sexual\* explicit).ti,ab.  
22 20 and 21  
23 sexting.ti,ab.  
24 ((sex\* or nud\*) adj2 (message\* or image\* or picture\* or photo\*)).ti,ab.  
25 23 or 24  
26 8 or 18 or 19 or 22 or 25  
27 \*Child/  
28 (child\* or girl\* or boy\*).ti,ab.  
29 (young people or young person\* or young wom?n or young m?n or young female\* or young male\* or  
young adult\* or youth\*).ti,ab.  
30 \*Young Adult/  
31 \*Adolescent/  
32 (adolescen\* or teenage\*).ti,ab.  
33 Juvenile Delinquency/  
34 delinquen\*.ti,ab.  
35 \*Minors/  
36 (minor or minors).ti,ab.  
37 \*Schools/  
38 school\*.ti,ab.  
39 \*"Latency Period (Psychology)"/  
40 \*Child, Preschool/  
41 (preschool\* or pre-school\*).ti,ab.  
42 (infant\* or toddler\* or youngster\* or early adult\* or kid or kids or underage or under age or teen\* or  
offspring\* or juvenile\* or student\*).ti,ab.  
43 or/27-42  
44 26 and 43

Intervention Terms – Specific Search

Population Terms (1-44) above

AND

45 Cognitive Therapy/ or Behavior Therapy/  
46 inter-agency.ti,ab.

23

423 47 lucy faithfull foundation.ti,ab.  
 424 48 ((sexual violence against children and vulnerable people national group) or SVACV).ti,ab.  
 425 49 typology of abused children.ti,ab.  
 426 50 referral route\*.ti,ab.  
 427 51 youth justice system.ti,ab.  
 428 52 multisystemic therapy.ti,ab.  
 429 53 ((resilience or desistance) adj2 model\*).ti,ab.  
 430 54 abuse specific approach\*.ti,ab.  
 431 55 custodial setting\*.ti,ab.  
 432 56 developmental approach\*.ti,ab.  
 433 57 family support approach\*.ti,ab.  
 434 58 goal orientated.ti,ab.  
 435 59 holistic approach\*.ti,ab.  
 436 60 rehabilitative.ti,ab.  
 437 61 restorative approach\*.ti,ab.  
 438 62 safe care.ti,ab.  
 439 63 (J-SOAP-II or juvenile sex offender assessment protocol).ti,ab.  
 440 64 "latency age sexual adjustment and assessment tool".ti,ab.  
 441 65 letting the future in.ti,ab.  
 442 66 (services for teens engaging in problem sexual behaviour or STEPS-B).ti,ab.  
 443 67 turn the page project.ti,ab.  
 444 68 strengths based approach\*.ti,ab.  
 445 69 young people's project.ti,ab.  
 446 70 intervention\*.ti.  
 447 71 or/45-70  
 448 72 44 and 71  
 449 73 limit 72 to (english language and humans and yr="1990 -Current")  
 450  
 451 Intervention Terms – Sensitive Search  
 452 *Population Terms (1-44) above*  
 453 *AND*  
 454 74 intervention\*.ab.  
 455 75 \*Health Promotion/  
 456 76 \*Health Education/  
 457 77 \*Primary Prevention/  
 458 78 \*Secondary Prevention/  
 459 79 (promotion\* or campaign\* or program\* or initiative\* or information or prevent\* or educt\* or scheme\*).ti,ab.  
 460 80 or/74-79  
 461 81 44 and 80  
 462 82 limit 81 to (english language and humans and yr="1990 -Current")  
 463 83 82 not 72

References

Belton, E., Barnard, M., & Cotmore, R. (2014) *Turn the page: learning from a manualised approach to treating harmful sexual behaviour*. Impact and Evidence series. London: National Society for the Prevention of Cruelty to Children. 67.

Booth, A., Cantrell, A., Preston, L., Chambers, D., & Goyder, E. (2015) What is the evidence for the effectiveness, appropriateness and feasibility of group clinics for patients with chronic conditions? A systematic review. *Health Serv Deliv Res*, 3(46)

Braun, V., & Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative research in psychology*, 2006. 3(2): p. 77-101.

Carroll, C., Booth, A., & Lloyd-Jones, M. (2012). Should we exclude inadequately reported studies from qualitative systematic reviews? An evaluation of sensitivity analyses in two case study reviews. *Qualitative Health Research*, 22(10), 1425-1434

Cargo, M., Harris, J., Pantoja, T., Booth A., Harden, A., Hannes, K., Thomas, J., Flemming, K., Garside, R., & Noyes, J. (2017) Cochrane Qualitative and Implementation Methods Group Guidance Paper 3: Methods for Assessing Evidence on Intervention Implementation. *J Clin Epidemiol*. Dec 6. pii: S0895-4356(17)31334-3. doi: 10.1016/j.jclinepi.2017.11.028. [Epub ahead of print] PubMed PMID: 29223325.

Chaffin, M., Letourneau, E. J., & Silovsky, J. F. (2002). Adults, adolescents, and children who sexually abuse children: A developmental perspective. In J. Myers ( Ed.), *The APSAC handbook on child maltreatment* (pp. 205-232). Thousand Oaks, CA: Sage.

Creeden, K. (2013) 'Taking a Developmental Approach to Treating Juvenile Sexual Behavior Problems' *International Journal of Behavioral Consultation and Therapy* 8 (3-4) 12-16

Criminal Justice Joint Inspection (2013) *Examining multi-agency responses to children and young people who sexually offended: A joint inspection of the effectiveness of multi-agency work with children and young people in England and Wales who have committed sexual offences and were supervised in the community*. London: HM Inspectorate of Probation.

Critical Appraisal Skills Programme (2017). CASP (insert name of checklist i.e. *Qualitative Research*) *Checklist*. [online] Available at: URL. Accessed 13 July 2017.

Deacon, L., *Children's Social Care Services' Responses to Children Who Display Sexually Harmful Behaviour*. (Unpublished PhD thesis). 2013.

Draper, C. E., Errington, S., Omar, S., & Makhita, S. (2013). The therapeutic benefits of sport in the rehabilitation of young sexual offenders: A qualitative evaluation of the Fight with Insight programme. *Psychology of Sport and Exercise*, 14(4), 519-530.

Duane, Y., Carr, A., Cherry, J., McGrath, K., & O'Shea, D. (2002). Experiences of parents attending a programme for families of adolescent child sexual abuse perpetrators in Ireland. *Child Care in Practice*, 8(1), 46-57.

Geary, J., I. Lambie, and F. Seymour, *Consumer perspectives of New Zealand community treatment programmes for sexually abusive youth*. Journal of sexual aggression, 2011. 17(2): p. 181-195.

Gough, D., Thomas, J. and Oliver, S. (2012) *Clarifying differences between review designs and methods*. Systematic reviews, 1(1): p. 28.

- Hackett, S., Print, B. & C. Dey. (1998) *Brother nature? Therapeutic intervention with young men who sexually abuse their siblings* 354. 1998. p. 152-179.
- Hackett, S., H. Masson, & Phillips, S. (2005) *Services for Young People Who Sexually Abuse*. NSPCC, Youth Justice Board, NOTA: London.
- Hackett, S., Masson, H. & S. Phillips (2006) Exploring consensus in practice with youth who are sexually abusive: Findings from a Delphi study of practitioner views in the United Kingdom and the Republic of Ireland. *Child maltreatment*, 11(2): p. 146-156.
- Hackett, S. (2014) *Children and young people with harmful sexual behaviours* 355. Research in practice research reviews, 15: p. 146.
- Harris JL, Booth A, Cargo M, Hannes K, Harden A, Flemming K, Garside R, Pantoja T, Thomas J, Noyes J. (2017) Cochrane Qualitative and Implementation Methods Group Guidance series - paper 6: Methods for question formulation, searching and protocol development for qualitative evidence synthesis. *J Clin Epidemiol*. Dec 14. pii: S0895-4356(17)31355-0. doi: 10.1016/j.jclinepi.2017.10.023. [Epub ahead of print] PubMed PMID: 29248725.
- Harden, A., Thomas, J., Cargo, M, Harris, J., Pantoja, T., Flemming, K., Booth, A., Garside, R., Hannes, K., & Noyes, J.. (2017) Cochrane Qualitative and Implementation Methods Group Guidance Paper 4: Methods for integrating qualitative and implementation evidence within intervention effectiveness reviews. *J Clin Epidemiol*. Dec 11. pii: S0895-4356(17)31354-9. doi: 10.1016/j.jclinepi.2017.11.029. [Epub ahead of print] PubMed PMID: 29242095.
- Hannes, K., & Macaitis, K. (2012). A move to more systematic and transparent approaches in qualitative evidence synthesis: update on a review of published papers. *Qualitative Research*, 12(4), 402-442.
- Halse, A., Grant, J., Thornton, J., Indermaur, D., Stevens, G., & Chamarette, C. (2012). Intrafamilial adolescent sex offenders' response to psychological treatment. *Psychiatry, Psychology and Law*, 19(2), 221-235.
- Homant, R.J. & Osowski, G. (1982) The politics of juvenile awareness programs: A case study of JOLT. *Criminal justice and behavior* 9 (1): p. 55-68.
- Jones, S. (2015) Parents of adolescents who have sexually offended: providing support and coping with the experience. *Journal of interpersonal violence*, 30(8): p. 1299-1321.
- Kelle, U. (2006). Combining qualitative and quantitative methods in research practice: purposes and advantages. *Qualitative research in psychology*, 3(4), 293-311
- Klenowski, P.M., Bell, K.J. & Dodson, K.D. (2010) An empirical evaluation of juvenile awareness programs in the United States: can juveniles be "scared straight"? *Journal of Offender Rehabilitation*. 49(4): p. 254-272.
- Lambie, I., Hickling, L., Seymour, F., Simmonds, L., Robson, M., & Houlahan, C. (2000). Using wilderness therapy in treating adolescent sexual offenders. *Journal of sexual aggression*, 5(2), 99-117.
- Lawson, L., Becoming a success story: How boys who have molested children talk about treatment. *Journal of psychiatric and mental health nursing*, 2003. 10(3): p. 259-268.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

Letourneau, E., & Borduin, C. (2008) 'The Effective Treatment of Juveniles Who Sexually Offend: An ethical imperative' *Ethics & Behavior* 18 (2-3) 286-306

Letourneau, E. J., Henggeler, S. W., McCart, M. R., Borduin, C. M., Schewe, P. A., & Armstrong, K. S. (2013). Two-year follow-up of a randomized effectiveness trial evaluating MST for juveniles who sexually offend. *Journal of Family Psychology*, 27(6), 978.

Martin, S., (1994) Sex offender treatment: An uphill journey. *Educational Psychology*, University of Calgary.

Masson, H. (2001) *Children and Young People Who Sexually Abuse Others. A report to inform the initial work of NOTA's National Committee on Sexual Abuse by Young People.* . (un-published report).

Miller, D.L. (2011) Being Called to Account Understanding Adolescents' Narrative Identity Construction in Institutional Contexts. *Qualitative Social Work*,. 10(3): p. 311-328.

Myers, J.E. (2002) *The APSAC handbook on child maltreatment*. Sage.

NCH, (1992), *The Report of the Committee of Enquiry into Children and Young People who Sexually Abuse Other Children*. NCH: London.

National Institute for Health and Care Excellence (NICE) (2012) *Methods for the development of NICE public health guidance (third edition)*. retrieved from: [https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0089896/pdf/PubMedHealth\\_PMH0089896.pdf](https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0089896/pdf/PubMedHealth_PMH0089896.pdf)

National Institute for Health and Care Excellence (NICE) (2016) *Harmful sexual behaviour among children and young people*. Retrieved from <https://www.nice.org.uk/guidance/ng55>

Noyes, J. & Lewin, S. *Chapter 5: Extracting qualitative evidence*. Supplementary guidance for inclusion of qualitative research in Cochrane systematic reviews of interventions. Version, 2011. 1: p. 1-24.

Pawson, R., Greenhalgh, T., Harvey, G., Walshe, K. (2004) *Realist synthesis: an introduction*. Manchester: ESRC Research Methods Programme, University of Manchester,.

Popay, J (2005) Moving beyond floccinaucinihilipilification: enhancing the utility of systematic reviews. *Journal of Clinical Epidemiology* 58: 1079- 1080

Pierce, S., (2011) The lived experience of parents of adolescents who have sexually offended: I am a survivor. *Journal of forensic nursing*,. 7(4): p. 173-181.

Ryan G (2000) 'Childhood Sexuality: A decade of study. Part 1 – research and curriculum development' *Child Abuse & Neglect* 24 (1) 33-48

Slattery, P., Cherry, J., Swift, A., Tallon, M., & Doyle, I. (2012). From custody to community: Development of assessment and treatment for juveniles serving sentences for sex offences in an Irish context. *Journal of sexual aggression*, 18(1), 81-90.

Smith, C., Allardyce, S., Hackett, S., Bradbury-Jones, C., Lazenbatt, A., & Taylor, J. (2014). Practice and policy in the UK with children and young people who display harmful sexual behaviours: an analysis and critical review. *Journal of Sexual Aggression*, 20(3), 267-280.

- 619 Somervell, J., & Lambie, I. (2009). Wilderness therapy within an adolescent sexual offender treatment  
620 programme: A qualitative study. *Journal of sexual aggression*, 15(2), 161-177.  
621
- 622 Thomas, J. and A. Harden, Methods for the thematic synthesis of qualitative research in systematic  
623 reviews. *BMC medical research methodology*, 2008. 8(1): p. 45.
- 624 Wilson, T.D. & Stone, J.I. (1985) More on telling more than we can know. In P. Shaver (Ed.),  
625 *Review of Personality and Social Psychology* vol 6 pp 167 – 183), Beverly Hills, CA: Sage  
626
- 627 Wilson, T. D. (1990). Self-persuasion via self-reflection. In *Self-inference processes: The Ontario*  
628 *symposium* (Vol. 6, pp. 43-67). Hillsdale, NJ: Erlbaum.  
629
- 630 Wylie, L. A., & Griffin, H. L. (2013). G-map's application of the Good Lives Model to adolescent  
631 males who sexually harm: A case study. *Journal of sexual aggression*, 19(3), 345-356.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47

Table 1 – Characteristics of included studies

Study Identifier	Country	Perspective	Programme	Methodology	Data Collection	Analysis
Belton et al., (2014)	United Kingdom	Adolescent males with harmful sexual behavior who had completed the programme (n=8), parent or carer (n=9)	Change for Good	Case study approach	Interviews	Thematic analysis
Draper et al., (2013)	South Africa	Adolescent males (n=17), parents (n=7), and a comparison group of youth offenders (n=10)	Fight With Insight	Case study approach	Focus groups	Thematic analysis
Duane et al., (2002)	Ireland	Parents (n=5) who had sons who had committed sexual offences	The Northside Interagency Project	Descriptive-exploratory	Interviews	Thematic analysis
Geary et al., (2011)	New Zealand	Adolescents (n=24, one female), parents or parental figure. The length of time on the programme spanned 6 months to more than 24 months.	Community treatment programme based on The Good Way model	Process evaluation component	interviews	Thematic analysis
Halse et al., (2012)	Australia	Adolescent males (n=12) who had committed intrafamilial sex	The SafeCare Young People’s Program	Phenomenology	Interviews	Thematic analysis

		offences. Interviews 12 months after completing programme	(SYPP)			
Jones, (2014)	United States	Parents of adolescent male sex offenders	Family Treatment Program (FTP). Support group for families of adolescent male sex offenders	Not described	Focus group and interviews	Content analysis and constant comparison
Lambie et al., (2000)	New Zealand	Parents (n=12) and adolescent males (n=4)	Wilderness Therapy (WT)	Process evaluation	Interviews	Content analysis
Lawson, (2003)	United States	Adolescent males (n=7) who had completed treatment for sexual offenses	Multi systems model	Grounded theory	Written answers to questions and interviews	Constant comparison
Martin,(2004)	United States	Adolescent males (n=7) progressing through sex offender treatment	Not specified	Not described	Interviews	Thematic analysis
Miller, (2011)	United States	Adolescent females (n=7) who had been (or were still) in a residential correctional facility	Think It Over program	Not described	Interviews	Thematic analysis
Pierce, (2011)	United States	Parents or parental figures (n=4)	Family Treatment Program (FTP)	Ethnography	Observations and interviews	Content analysis and constant



1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47

						comparison
Slattery et al., (2012)	Ireland	Adolescent male sex offenders (n=11)	The Baseline Project	Not described	Interviews	Thematic analysis
Somervell & Lambie, (2009)	New Zealand	Adolescent males (n=7)	Wilderness Therapy (WT)	Essentialist/realist perspective:	Observation and interviews	Thematic analysis

## Appendix A – Quality Assessment

Reference	Qualitative approach	Data Collection	Study Purpose	Study Design	Role of Researcher	Context	Reliable Methods	Rigorous Data Analysis	Rich Data	Reliable Analysis	Convincing Findings	Relevant Findings	Conclusions	Clear & Coherent Reporting	Overall Rating
Belton et al (2014) [T]	Appropriate	Appropriate	Clear	Defensible	Unclear	Not Sure	Reliable	Rigorous	Rich	Not Sure	Convincing	Relevant	Adequate	Appropriate	+
Draper et al (2013)	Appropriate	Appropriate	Clear	Defensible	Clear	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	++
Duane et al (2002)	Appropriate	Not Sure	Mixed	Not Sure	Partially Clear	Not Sure	Not Sure	Not Sure	Poor	Reliable	Convincing	Relevant	Adequate	Appropriate	+
Geary et al (2011) [T]	Appropriate	Appropriate	Clear	Defensible	Partially Clear	Clear	Reliable	Rigorous	Poor	Reliable	Convincing	Relevant	Adequate	Appropriate	++
Halse et al (2012) [T]	Appropriate	Appropriate	Clear	Defensible	Clear	Clear	Reliable	Rigorous	Not Sure	Reliable	Convincing	Relevant	Adequate	Appropriate	++
Jones (2014)	Appropriate	Appropriate	Clear	Defensible	Partially Clear	Clear	Reliable	Rigorous	Not Sure	Reliable	Convincing	Relevant	Adequate	Appropriate	+
Lambi et al	Appropriate	Appropriate	Clear	Defensible	Clear	Clear	Reliable	Rigorous	Not	Reliable	Convincing	Relevant	Adequate	Appropriate	-

(2000)									Sur e						
Lawson (2003)	Approp riate	Approp riate	Clear	Defens ible	Clear	Clear	Relia ble	Rigor ous	No t Sur e	Relia ble	Convin cing	Relev ant	Adequat e	Approp riate	-
Martin (2004)	Approp riate	Approp riate	Clear	Defens ible	Partiall y Clear	Clear	Relia ble	Rigor ous	No t Sur e	Relia ble	Convin cing	Relev ant	Adequat e	Approp riate	-
Miller (2011)	Approp riate	Approp riate	Clear	Defens ible	Clear	Clear	Relia ble	Not Sure	No t Sur e	Not Sure	Not Sure	Not Sure	Adequat e	Approp riate	+
Pierce (2011)	Approp riate	Approp riate	Clear	Not Sure	Unclear	Clear	Relia ble	Rigor ous	Ric h	Relia ble	Convin cing	Relev ant	Adequat e	Approp riate	+
Slatter y et al (2012)	Approp riate	Not Sure	Mixe d	Not Sure	Unclear	Clear	Relia ble	Not Sure	No t Sur e	Not Sure	Not Sure	Relev ant	Not Sure	Approp riate	-
Somer vell & Lambi e (2009)	Approp riate	Approp riate	Clear	Defens ible	Clear	Clear	Relia ble	Rigor ous	No t Sur e	Relia ble	Convin cing	Not Sure	Adequat e	Approp riate	+

	Belton et al., (2014)	Draper et al., (2013)	Duane et al., (2002)	Geary et al.,(2011)	Halse et al., (2012)	Jones, (2015)	Lambie et al.,2000	Lawson,(200 3)	Martin, (2004)	Miller ,(2011)	Pierce ,(2011)	Slattery et al.,(2012)	Somervell & Lambie (2009)
<b>Practitioners</b>													
Roles	Y	Y		Y	Y								
Barriers and facilitators	Y	Y		Y					Y	Y			
Plus activities	Y	Y		Y				Y					Y
<b>Parents/carers</b>													
Roles				Y		Y							
Barriers and facilitators	Y	Y	Y	Y	Y	Y		Y	Y		Y		
<b>Seeing the bigger picture/ Child focused/ Tailored</b>													
Addressing wider factors	Y			Y	Y			Y	Y	Y		Y	
Abused and abuser										Y			
<b>Communication and disclosure (as mechanism and outcome)</b>													
Group work		Y	Y	Y		Y				Y			
One to one work				Y		Y							
Challenges			Y	Y		Y			Y		Y		
Parent-child communication			Y			Y					Y		
Benefits	Y	Y	Y	Y	Y			Y		Y			Y
<b>Developing self and learning skills</b>													
Barriers to engagement	Y								Y				
Accepting responsibility		Y		Y	Y		Y	Y		Y			
Rebuilding trust								Y					
Anger management skills	Y	Y		Y	Y								
Communication skills				Y				Y					Y
Relapse prevention	Y			Y			Y	Y	Y				
Victim empathy				Y			Y		Y				

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47

Self respect/esteem		Y			Y			Y				
Sexual abuse cycle/triggers	Y	Y	Y	Y	Y		Y	Y	Y			Y
Improved relationships	Y	Y	Y	Y	Y		Y	Y			Y	Y
<b>Moving forwards</b>												
Lack of follow-up			Y	Y								
More than an offender	Y									Y	Y	
Hope					Y				Y	Y		